SOCIAL SECURITY

Office of Retirement and Disability Policy

July 15, 2013

The Honorable Sam Johnson
Chairman, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for your May 14, 2013 letter requesting additional information to complete the record for the hearing on disability decisions. Enclosed you will find the answers to your questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030.

Sincerely,

Arthur R. Spencer
Associate Commissioner
for Disability Programs

Enclosure

Questions for the Record
For the March 20, 2013 Hearing
On Disability Decisions
Questions from Chairman Johnson

1. **In your testimony, you indicated that the Social Security Administration (SSA) has an interagency agreement with the Bureau of Labor Statistics (BLS) to test occupational data collection methods that could lead to the development of a new Occupational Information System to replace the long outdated Dictionary of Occupational Titles (DOT).**

   a) **How much will SSA spend on the interagency agreement with BLS from start to finish? What is the timetable for testing and use of the new system if testing is successful? When will adjudicators have a tool in their hands they can use?**

   At this time, we cannot provide actual costs because those costs will depend on the results of ongoing feasibility testing. Last fiscal year (FY), we spent $392,000 on the interagency agreement. This fiscal year, we anticipate spending $10.8 million. We anticipate spending $14.8 million in FY 2014 and $16 million in FY 2015.

   Our timetable for the new system is as follows:

FY 2013	• At the beginning of this fiscal year, BLS began implementing its data collection test plan.
FY 2014	• BLS will continue testing any outstanding issues and will conduct a small-scale production test to prepare for the full-scale data collection. The small-scale production test will not include a full sample and will be based on the FY 2013 testing result.
FY 2015	• Depending on FY 2014 small-scale production test results, BLS may begin gathering full-scale production data, some of which may be available in FY 2016. • After full-scale production data is complete, we will test the effects of using the data in our adjudicatory process prior to full-scale implementation.

   Adjudicators may be able to use the new occupational information system (OIS) as early as FY 2016. This date depends on the results of the small-scale production test, the gathering of actual production data, and testing the production data in our adjudicatory process.

   To be clear, we are working with BLS to develop current occupational data for use in our disability programs. BLS is not updating or replacing the DOT.

b) When did efforts to update the DOT begin? How much funding has been spent to date?

The OIS project began in FY 2008 with initial research exploring whether the Department of Labor's Occupational Information Network (O*NET) or other occupational classification systems could meet our disability evaluation needs. We determined that neither O*NET nor any other then currently available system would be able to meet our requirements without modification. From FY 2009 to FY 2012, we convened the Occupational Information Development Advisory Panel (OIDAP). The OIDAP consisted of experts in industrial and organizational psychology, worker rehabilitation, and disability program law. The OIDAP made recommendations to us regarding OIS development and held regular public meetings that allowed stakeholders to share their advice and concern regarding the development of our OIS. In July 2012, the charter for the OIDAP expired and we entered into an interagency agreement with BLS to help support the development of new occupational data for us.

From FY 2008 through FY 2012, we spent roughly $3.8 million on the OIS project.

OIS Spending by Fiscal Year

Fiscal Year		Spending
2008	$	665,000
2009	$	342,000
2010	$	815,000
2011	$	990,000
2012	$	984,000
Total	$	3,796,000

Please note that the FY 2012 figure includes the $392,000 that we spent on the interagency agreement with BLS.

2. What standard qualifications are in place for vocational experts used by the DDSs and/or used by the Administrative Law Judges (ALJs)? How are they trained?

At the State level, disability determination services (DDS) agencies do not use vocational experts (VEs). Instead, they use vocational specialists who know how to apply vocational factors to a specific medical-vocational determination. Using its own personnel standards, each State DDS determines which employees qualify as vocational specialists.

Regarding vocational specialist training, we have developed a wide variety of vocational training resources that any DDS adjudicator can access directly from his or her personal computer workstation. These training resources include PowerPoint slides, desk guides, online case studies, and numerous videos on demand (VOD). We have also converted a previous three-day headquarters "Vocational Specialist" training into a series of VODs that DDS employees can access at their workstations called "Vocational Specialist at the Desktop" training. This series provides DDS employees with training on complex vocational

policy areas, such as residual functional capacity, remaining occupational base, and Steps 4 and 5 of the sequential evaluation process.

At the hearing level, we use VEs. VEs are independent contractors. To qualify as a VE, a contractor must be trained and skilled to render impartial opinions relevant to evidence at the hearing level of the disability claims process. A VE should have current knowledge of the following:

- working conditions and physical demands of various occupations;
- transferability of skills;
- the existence and number of jobs at all exertional levels in the national economy; and
- job placement for workers with disabilities.

The VE should also possess the following:

- up-to-date knowledge of, and experience with, industrial and occupational trends and labor market conditions;
- an understanding of how we determine whether a claimant is disabled;
- current and extensive experience in counseling and job placement of people with disabilities; and
- knowledge of, and experience using, vocational reference sources. These sources include the DOT, County Business Patterns by the Bureau of the Census, the Occupational Outlook Handbook published by BLS, and any occupational surveys of occupations prepared for us by various State employment agencies.

Because VEs are independent contractors, we do not provide their training. However, we have developed a VE orientation PowerPoint presentation that our regional offices share with their VEs.

3. Is there a process in place for the SSA to respond to recommendations from the Administrative Conference? If yes, please describe.

Once we receive a report and recommendations from the Administrative Conference of the United States (ACUS), our internal components with the related subject matter expertise perform detailed reviews of the report and conduct any necessary additional research. The components work together to evaluate which of ACUS' recommendations best address the issue or area of concern that we asked ACUS to study, while simultaneously weighing the challenges that we face in the current environment. The components will reach agreement on the best course of action, which may or may not include implementing the ACUS recommendations or versions of the recommendations.

4. **Since 2003, Social Security's disability programs have remained on the Government Accountability Office's high-risk list because they rely on out-of-date criteria in making disability benefit decisions. Social Security is in the process of performing comprehensive updates of each of the fourteen body systems in the Listing of Impairments used to determine if someone is disabled, but some of the reviews have been ongoing for the last 19 to 33 years. Two of the listings, mental and neurological disorders, have not been comprehensively revised for more than 27 years. Why the delay? In addition, please provide a table which provides detailed information regarding the status of each listing update. Please also include a summary of the process for how listings are updated.**

   We are currently revising our Listing of Impairments (Listings) governing the evaluation of mental and neurological disorders through the multi-step rulemaking process. These revisions will reflect current medical knowledge and practices, advances in medical technology, and our adjudicative experience.

   We have made a commitment to update all of our Listings, recognizing that some Listings have not been updated in many years. These Listings are complicated, and we want to make sure that we revise them correctly. To some extent, the complexities of certain body systems, such as mental and neurological, have caused the delays in updating the corresponding Listings.

   I have enclosed a chart that provides the status of each Listing update (Enclosure 1) and a summary of the process for how we update Listings (Enclosure 2). Please note that the chart reflects the anticipated dates of publication as published in the fall 2012 Unified Agenda. We will be making some changes to the anticipated dates of publication for some of the Listings, and these changes will be published in the spring 2013 Unified Agenda.

5. **Please explain why, in Fiscal Year 2012, the Puerto Rico Disability Determination Services (DDS) awarded benefits 59.1 percent of the time, when Mississippi DDS awarded benefits 25 percent of the time.**

   Our research indicates that factors outside of the DDS' or our control substantially affect State-to-State variation in allowance rates. These factors include the composition of initial determinations by age, gender, primary diagnosis, and the presence of a secondary diagnosis. Claim filing rates also vary from State-to-State, and this can significantly affect allowance rates. Historically, States with high filing rates tend to have low allowance rates and vice-versa. Other State characteristics, such as economic conditions, demographics, and health levels, correlate strongly with the filing rate. Consequently, these characteristics indirectly influence the allowance rate.

   In addition, there is no Supplemental Security Income (SSI) program in Puerto Rico, so its allowance rate is only for Social Security Disability Insurance (SSDI) claims. SSI determinations tend to have a much lower allowance rate and pull down a State's overall allowance rate. Other States with SSDI allowance rates that are comparable to Puerto Rico include Wyoming,

New Hampshire, New Jersey, South Dakota, Vermont, North Dakota, and Massachusetts; these States have allowance rates that range from roughly 62 to 50 percent. The national allowance rate for FY 2012 for SSDI claims is 42.5 percent.

6. **What responsibilities does a claimant have in the development of their claim and in the appeal of a previous decision? What responsibilities does the agency have? Are these responsibilities required by statute, regulation, or agency policy?**

Regardless of the level of adjudication, the Social Security Act (Act) and our regulations make proving disability the claimant's responsibility. The Act requires a claimant to provide medical and other evidence showing that he or she is disabled. Section 223(d)(5)(A) of the Act, 42 U.S.C. 423(d)(5)(A). See also section 1614 of the Act, 42 U.S.C. 1382c(a)(3)(H)(i) (applying the provisions of section 223(d)(5) to disability determinations under title XVI). Our regulations specify that a claimant must provide evidence, without redaction, showing how his or her impairment(s) affects his or her functioning and any other information that we need to decide the claim. Our regulations further require a claimant to provide, if we request it, evidence regarding non-medical factors that demonstrate how a claimant's impairment(s) affects his or her ability to work (such as activities of daily living). 20 C.F.R 404.1512(c) and 416.912(c).

The Act also requires us to develop a complete medical history of at least the preceding 12 months before we deny a disability claim. When deciding a disability claim, we must make every reasonable effort to obtain the medical evidence that we need from the claimant's medical sources. Section 223(d)(5)(B) of the Act, U.S.C. 423(d)(5)(B). See also section 1614 of the Act, 42 U.S.C. 1382c(a)(3)(H)(i). If the claimant's medical sources cannot or will not give us sufficient medical evidence to decide the claim, our regulations allow us to purchase a consultative examination or test. 20 C.F.R. 404.1517 and 416.917.

7. **What are the qualifications for a DDS examiner? How does Social Security ensure that training is provided consistently nationwide to DDS examiners? What professional development and continuing education opportunities are offered to ensure examiners have the skills needed to make decisions effectively?**

Each State DDS determines which employees qualify as examiners pursuant to its own personnel standards, and the professional development and continuing educational opportunities offered to its examiners. We do not provide specific professional development and continuing educational opportunities, but we provide policy-compliant training materials on all aspects of the disability program. We also provide training materials to address new or updated policy, processes, initiatives, and quality trends. We design our training to meet the needs of all staff and address State-specific needs. All of our training materials are readily available to all DDSs via our Intranet, VODs, and video conferences. In addition, we provide training through other formats, such as on-site training.

8. **At this Subcommittee's March 13, 2013 hearing, we learned that some people are receiving benefits for as many as 12 years on average. If a person was determined to be disabled 12 years ago and their condition has not changed, but they would not qualify for disability under today's standards, what happens?**

In your scenario, we would most likely continue benefits even if the beneficiary would not qualify under today's standards. When conducting a continuing disability review (CDR), the Act requires us to use the Medical Improvement Review Standard. When applying this standard, we begin by comparing the beneficiary's current condition to the findings related to that condition when we last found the beneficiary disabled. Thus, we would compare the beneficiary's current condition to findings from 12 years ago. Before we terminate eligibility, we would have to show:

- medical improvement in the beneficiary's condition;
- increase in their ability to perform basic work activity; and
- ability to engage in substantial gainful activity.

However, there are exceptions to this rule. For example, if the beneficiary became eligible through fraud, we would immediately re-determine that eligibility even if the condition were unchanged.

9. **Recently, Social Security changed the process for determining if a person can work by having examiners look at jobs in the national economy before looking at past work. Please explain the policy and why it was implemented.**

In July 2012, we issued regulations that gave adjudicators the discretion to proceed to Step 5 of sequential evaluation when we have insufficient information about a claimant's past relevant work history to make a finding at Step 4. We implemented this policy to expedite cases in which the adjudicator currently does not have sufficient vocational evidence to evaluate work at Step 4 but is able to deny the claim at Step 5. Vocational development can be extremely time-consuming, and this expedited process can save valuable processing time by appropriately making a "not disabled" determination at Step 5. Of course, if we find that the claimant may be unable to adjust to other work at Step 5 or if one of our special medical-vocational profiles may apply, the adjudicator will return to Step 4 to develop the claimant's work history and make a finding about whether the claimant can perform his or her past relevant work.

Our revised policy states:

- If there is enough vocational evidence in the file to find that the claimant can perform at least one past relevant job (either as he or she performed it or as it is generally performed in the national economy), the adjudicator should deny the claim at Step 4 of sequential evaluation.

- If there is not enough vocational evidence to determine whether the claimant is able to perform past relevant work, the adjudicator may either develop the vocational

evidence to evaluate the claim at Step 4 or proceed to Step 5. Before using the expedited process, the adjudicator will first consider whether any of the special medical-vocational profiles might be applicable.

- If the adjudicator can determine that the claimant can adjust to other work in the national economy, he or she will deny the claim at Step 5.

- If the adjudicator cannot deny the claim at Step 5, he or she must return to Step 4 and develop the needed vocational evidence regarding past relevant work.

10. A paper recently released by Jeff Liebman and Jack Smalligan suggests temporarily switching Social Security's State DDS costs from discretionary to mandatory spending. They believe this change would provide the resources the agency needs to stay current with continuing disability reviews, better document claims at the initial application step, and reduce case backlogs. After 5 years, Social Security would have to demonstrate that the increased expenditures more than pay for themselves with reduced spending. What are the agency's views regarding this proposal?

Jeff Liebman and Jack Smalligan developed some interesting proposals related to the SSA disability program, which we are currently reviewing. Thus, we are not ready to offer views on the specific proposals relating to the future of DDS funding.

However, on a similar idea relating to mandatory funding, the President's Budget for FY 2014 includes a special legislative Administration proposal that would provide a reliable stream of mandatory funding to significantly ramp up our program integrity work. Program integrity work ensures that only those eligible for benefits receive them.

The annual appropriations process has not provided us with the resources necessary to conduct all of our scheduled CDRs and redeterminations, leading to a backlog of 1.3 million CDRs. We estimate that each additional dollar spent on CDRs would save the Federal Government $9 and each additional dollar spent on redeterminations would save the Federal Government $5.

The proposal would create a new Program Integrity Administrative Expenses account, which would be separate from our Limitation on Administrative Expenses account. The new account would cover a substantial amount of our costs for CDRs and redeterminations over the next 10 years. If approved, the funds would be available for two years and would provide us with the flexibility to aggressively hire and train staff to support the processing of more program integrity work. The Budget proposal would lead to net savings of $38 billion over 10 years.

In FY 2014, the budget proposal would provide $1.227 billion, allowing us to handle significantly more CDRs. With this increased level of funding, the associated volume of medical CDRs is 1.047 million, although it may take time to ramp up to that level. For comparison, we conducted 443,000 CDRs in FY 2012.

11. The Inspector General's testimony highlighted findings from a July 2012 audit regarding administrative finality, indicating that the SSA agreed to review and evaluate administrative finality policies. What specific progress has been made?

We formulated several ideas for changing the rules of administrative finality. We intend to vet these ideas with external stakeholders, including the public.

Enclosures (2)

Enclosure 1 – The Honorable Sam Johnson

Status of the Medical Listings Revisions

Body System	Current Status
Growth Impairments NPRM*	NPRM published 5/22/13 at 78 FR 30249; public comment period closes 7/22/13.
Musculoskeletal System NPRM	NPRM drafted. Anticipated date of publication: 11/2014.
Special Senses - Vision final rule Special Senses - Hearing Loss and Disturbances of Labyrinthine-Vestibular Function ANPRM**	Final rule published 3/28/13 at 78 FR 18837. ANPRM drafted.
Respiratory System NPRM	NPRM published 2/4/13 at 78 FR 7968; reviewing public comments to begin drafting the proposed final rule.
Cardiovascular System NPRM	Drafting NPRM. Anticipated date of publication: 4/2014.
Digestive System NPRM	NPRM drafted. Anticipated date of publication: 6/2014.
Genitourinary Impairments NPRM	NPRM published 2/4/13 at 78 FR 7695; reviewing public comments to begin drafting the proposed final rule.
Hematological Disorders NPRM	NPRM drafted. Anticipated date of publication: 11/2013.
Skin Disorders NPRM	NPRM drafted. Anticipated date of publication: 12/2014.
Congenital Disorders that Affect Multiple Body Systems final rule	Final rule published 2/4/13 at 78 FR 7659.
Neurological NPRM	NPRM drafted. Anticipated date of publication: 12/2013.
Mental Disorders final rule	Drafting final rule.
Malignant Neoplastic Diseases NPRM	NPRM drafted. Anticipated date of publication: 3/2014.
Evaluating Human Immunodeficiency Virus Infection and Evaluating Functional Limitations in Immune System Disorders NPRM	NPRM drafted.
Language and Speech Disorders NPRM (proposed new Listing)	ANPRM published 2/6/12 at 77 FR 5734; Drafting NPRM. Anticipated date of publication: 11/2014.

*Notice of proposed rulemaking (NPRM)

**Advance notice of proposed rulemaking (ANPRM)

Business Process for Revising the Medical Listings

Background

The Listing of Impairments (Listings) revision process is an ongoing, multi-phase effort to update and revise the Listings, which describes, for each major body system, impairments considered severe enough to prevent an individual from doing any gainful activity, regardless of the individual's age, education, or work experience. In the case of children under age 18 applying for Supplemental Security Income (SSI), the listed impairments are severe enough to cause marked limitations in two domains of functioning or an extreme limitation in one domain. Most of the listed impairments are permanent or expected to result in death. For some impairments, the Listing includes a specific statement of duration. For all other Listings, the evidence must show that the impairment has lasted or is expected to last for a continuous period of at least 12 months. The criteria in the Listings are applicable for evaluation of claims for disability benefits under the Social Security disability program or payments under the SSI program.

The Listings are organized by major body systems—14 for adults (Part A) and 15 for children (Part B), although adult criteria can be applied to children if the disease processes have a similar effect on adults and children. We have over 100 listed impairments.

We update and revise the Listings to reflect the universal standard of care, as well as to include the latest advances in medical treatment and technology that affect a person's ability to function. The Listings also reflect our adjudicative experience through our own case reviews, the quality review system adjudicator feedback, as well as research and advocate input.

Listings Revision Process

There are five high-level phases involved in the Listings revision process: information gathering, drafting the Notice of Proposed Rulemaking (NPRM), completing the internal agency review process, publishing the NPRM in the *Federal Register* for public comment, and publishing the final rule in the *Federal Register*.

Since 2004, we have comprehensively updated approximately 70 percent of the listings and are on track to propose revisions in the *Federal Register* for all listings by the end of 2014. We are committed to completing targeted revisions of the Listings on a 5-year basis; the 5-year period starts after we complete the comprehensive body system revision.

Step 1: Information Gathering

Internal

Internally and almost immediately after a Listing is updated, disability claims adjudicators ask, and we respond to, questions about how to apply the recently updated medical criteria. We also review Request for Program Consultation (RPC) and Policy Feedback System (PFS) data to look

for trends in adjudicative practice that highlight the need for policy clarification. We developed the RPC process to resolve differences of opinions between adjudicators and quality reviewers concerning disability determinations. We post all RPC resolutions and related data on our Intranet to make them available to all agency staff. We use the information to identify issues and areas where we might improve disability policy. The PFS supports our initiative of improving disability policy by gathering data from the large amounts of programmatic information that we collect throughout the disability process and by using the data to identify areas for policy change and improvement.

We release a questionnaire to our internal users/adjudicators to solicit input about their experience using the revised medical criteria throughout a one-year period. In addition, our staff performs literature searches and research to learn about advancements and recent changes in medical treatment and technology.

External

One year after we implement revised medical criteria, we send a questionnaire to external advocacy and other interest groups to learn about their experience with the rules. The groups include patients, medical experts, technicians, clinicians, and the public. We maintain contact lists for each body system and a general contact list for our use to notify the public when our regulations are available in the *Federal Register* for public review and comment. Recently, we launched a test of an open government public engagement option to invite internal and external comments on an issue that will provide insight into our work to update and revise the Listings.

Formal Outreach

We conduct formal outreach by soliciting comments from the public and by meeting with advocacy and interest groups. We publish an Advance Notice of Proposed Rulemaking (ANPRM) in the *Federal Register* to provide information and pose specific questions that we believe will be helpful to solicit comments from the public that we can use to update and revise the Listings. In the past, we hosted public outreach conferences to give advocacy and other interest groups an opportunity to share their concerns and experience about certain impairments. Over the past four years, we have hosted these meetings internally or by teleconference due to budget constraints. We host these outreach meetings as needed and up to the point where we begin drafting the NPRM.

To keep the Listings medically up to date, it is critical that we get advice from independent medical experts in a variety of medical and clinical disciplines. We have partnered with the National Academy of Sciences (NAS), Institute of Medicine (IOM), to research the Listings and provide independent, unbiased, and authoritative medical and clinical advice. The IOM Committee of Medical Experts to Assist Social Security on Disability Issues is a standing multidisciplinary expert medical committee convened by the NAS. It provides us advice through meetings, workshops/symposiums, and Federal Advisory Committee Act (FACA)-compliant

consensus study committees. By having independent medical experts provide us with necessary updates, we maintain our objectivity, and by using FACA-compliant consensus study committees that include members that have clinical expertise in a particular body system, we quickly obtain publically available reports that provide us with advice and recommendations on improving the effectiveness of the Listings.

Under our previous contract which expired in December 2012, the IOM convened two consensus study committees (cardiovascular and immune/human immunodeficiency virus (HIV)) and produced two reports with 36 recommendations for improvements to the Listings that we use to evaluate cardiovascular disorders (28 recommendations) and HIV infection (8 recommendations). We have used these recommendations to draft NPRMs.

The current contract proposal provides for the continuation of an expert medical committee to advise the Commissioner on when we should revise the Listings to keep them up to date. For example, the first task order provides for a consensus study committee to evaluate our use of symptom validity testing in our disability evaluation process (including Step 3, at which we use the Listings) for both physical and mental impairments.

At the end of the information gathering phase and from all of the efforts outlined above, we compile a list of the issues and topics that we use to draft the NPRM.

Step 2: Draft NPRM

In the draft NPRM step, small teams consisting of medical policy analysts, medical officers, and other agency medical consultants, with occasional input from outside experts, work together to do research, analyze issues, and write regulations to update and revise the Listings. The body system lead analyst develops a work plan to conduct regular meetings to draft the NPRM. The team uses these meetings to draft proposed changes to the Listings (proposed medical criteria) and the introductory text (information that adjudicators need to use the Listings) and the preamble (explanation of changes to the Listings).

Before the team begins drafting the NPRM, they create an issue paper that contains the list of issues and topics that were compiled throughout the information gathering phase. The issue paper is used as a guide for the team to complete this phase of the process.

At the point where the team completes drafting the NPRM, we send the proposed rules to another agency component to review a number of previously adjudicated cases to learn about the potential impact of the proposed Listings. We analyze and summarize the case review impact and submit it to our Office of the Chief Actuary for its use to conduct a cost-benefit analysis for the agency.

Step 3: Complete Review Process

This step marks the beginning of the agency internal review process. Any ANPRM, NPRM, or proposed final regulation first undergoes an internal agency review. Then, we send the documents to the Office of Management and Budget (OMB) to obtain its review and approval to publish in the *Federal Register*. After OMB completes its review and approves the regulation, OMB returns it to the agency to obtain the Commissioner's signature before it is published in the *Federal Register*.

Step 4: Publish ANPRM/NPRM in *Federal Register* for Public Comment
The ANPRM/NPRM is published in the *Federal Register* for review and comment for usually 60 days. The public submits comments to www.regulations.gov.

Step 5: Publish Final Rule

In the publish final rule step, at the end of the NPRM public comment period, we review the public comments and consider them when drafting the proposed final rule. The proposed final rule undergoes an internal agency review. Then, we send the documents to OMB to obtain its review and approval to publish in the *Federal Register*. After OMB completes its review and approves the proposed final rule, it is returned to the agency to obtain the Commissioner's signature before it is published in the *Federal Register*.

We publish the final rule in the *Federal Register*, along with a summary of the public comments and how we addressed them. Simultaneously, we develop adjudicator training on the final rules to coincide with the rules' effective date.